

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010512

STATE FILE NUMBER

FILED MAR 26 1959

Registration District No. 294

Primary Registration District No. 2056

Registrar's No. 59

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moberly		c. CITY OR TOWN Moberly	
c. FULL NAME OF HOSPITAL OR INSTITUTION Woodland Hospital		d. STREET ADDRESS 7 1/2 Windsor Pl.	
3. NAME OF DECEASED (Type or print) First FRANCES Middle ADALAIDE Last GARNETT		4. DATE OF DEATH Month MARCH Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Bucklin, Missouri	
13a. FATHER'S NAME J. C. Lawson		14. NAME OF HUSBAND OR WIFE E. L. Garnett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 489-10-9806	
17. INFORMANT E. L. Garnett		Address Moberly	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease - with complete heart block Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 20 years unknown
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 4200	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
20f. CITY, TOWN, OR LOCATION _____		COUNTY _____ STATE _____	
21. I attended the deceased from Dec 19 1958 to March 15 1959 and last saw her alive on March 14 1959 Death occurred at 8 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Charles E. Cohen MD		22b. ADDRESS 317 Virginia Instaly Rd	
22c. DATE SIGNED March 16 1959			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 19, 1959	
23c. NAME OF CEMETERY OR CREMATORY ✓		23d. LOCATION (City, town, or county) (State) Sturgeon Missouri	
24. FUNERAL DIRECTOR Mahan Funeral Service		ADDRESS Moberly	
25. DATE RECD. BY LOCAL REG. 3-19-59		REGISTRAR'S SIGNATURE Charles E. Cohen	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 30 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student

Signature of Student Embalmer

Signed *John A. Green*

Licensed Embalmer No. *3815*

P. O. Address *Maryland*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.